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IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF SAN FRANCISCO
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PATRICIA HENLEY,
Plaintiff,
vs. No. 995172
PHILIP MORRIS, INCORPORATED, et al.,
Defendants.
_____/

DEPOSITION OF

DAVID ROSENBACH, M.D.

Wednesday, December 16, 1998

REPORTED BY:

HOLLY THUMAN, CSR NO. 6834, RPR

TOOKER & ANTZ
COURT REPORTING & VIDEO SERVICES
818 MISSION STREET, FIFTH FLOOR
SAN FRANCISCO, CALIFORNIA 94103

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EXHIBITS

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BE IT REMEMBERED that on Wednesday, December 16, 1998 commencing at 9:10 a.m., thereof, at Shook, Hardy & Bacon, One Market, Steuart Tower, Ninth Floor, San Francisco, California, before me, HOLLY THUMAN, duly authorized to administer oaths pursuant to Section 2093(b) of the California Code of Civil Procedure, personally appeared
DAVID ROSENBACH, M.D.,
called as a witness, who, having been first duly sworn, was examined and testified as hereinafter set forth.
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APPEARANCES
WARTNICK, CHABER, HAROWITZ, SMITH & TIGERMAN, 101 California Street, Suite 2675, San Francisco, California 94111, represented by MADELYN CHABER, Attorney at Law, appeared as counsel on behalf of the Plaintiffs.
SHOOK, HARDY & BACON, One Market, Steuart Tower, Ninth Floor, San Francisco, California 94105, represented by GERALD BARRON and LUCY MASON, Attorney at Law, appeared as counsel on behalf of Defendant Philip Morris Incorporated; and
SHOOK, HARDY & BACON, One Kansas City Place, 1200 Main Street, Kansas City, Missouri 64105-2118,
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represented by CURTIS L. PERRY, Attorney at Law, appeared as counsel on behalf of Defendant Philip Morris, Incorporated.
Also present were JANE ASCHEMAN and ALLAN FEINGOLD.
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December 16, 1998 9:10 a.m.
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EXAMINATION BY MS. CHABER
MS. CHABER: Q. Dr. Rosenbach, my name is Madelyn Chaber, and I represent Patricia Henley in this suit against Philip Morris.
Have you ever had your deposition taken before?
A. Yes.

Q. On how many occasions?
A. Oh, maybe 20 times.
Q. And can you give me an idea of the nature of those type of depositions?
A. Most of the time -- most of the time, it relates to radiographic findings in people who have had motor vehicle accidents and are claiming injury.
Q. And does that generally tend to be either soft tissue or bony structure --
A. It doesn't leave much else. There's neurologic tissue, I guess we have to include.
Q. And have you testified in a courtroom before?
A. Yes.
Q. On how many occasions?
A. Probably less than ten.
Q. And were each of those times that you went to

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court and testified also cases that you had had your deposition taken in?
A. Probably, although I know of at least one case in which I was a consultant on a medical malpractice issue. I had no deposition taken prior to my appearance in court.
Q. And on that medical malpractice issue, on whose behalf were you testifying?
A. The defense.
Q. And was that a hospital or a doctor, or a combination?
A. The doctor.
Q. And on the motor vehicle type accident cases -- general personal injury I guess you would refer to them as -- can you indicate which side you were on, or percentage side?
A. A ballpark figure would be, about 70 percent for the defense and 30 percent for the plaintiff.
Q. And on those cases where you would be testifying on behalf of the plaintiff, would it be as a treater or a participant in the case of that individual, as opposed to a retained expert who had been called in separate and apart from the care and treatment?
A. Actually, I have to address the previous question, because when I said 70/30, that really

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referred to what percentage of times I'm consulted as an independent reviewer.
The number of times I go to court -- and I'm sorry, I misunderstood -- I would say it probably breaks down closer to 90 percent for the defense and 10 percent for the plaintiff.
When I go to court, to answer this question, I review films independently. People bring them to my practice, and I might be the one who's looking at them.
Q. And you understand that you're under oath in this deposition?
A. That's what I just swore to moments ago.
Q. And that's the same oath as if you were appearing in a court of law?
A. I understand that.
Q. If you have any concerns or do not understand any questions that I ask, I would ask you to ask me to rephrase them or let me know what part of my question you have a problem with.
Will you do that, sir?

A. Yes.
Q. I have been provided, and there's been a very brief discussion off the record -- I've been provided with some materials from Dr. Rosenbach, one being his CV. And we'll attach that as Plaintiff's first in

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order, Plaintiff 1. We can mark them after. I'll just put a number on the back.
Is this a copy that the court reporter may keep, or do we need to make copies of it?
MR. BARRON: I think she may keep it.
MS. CHABER: Okay. There are other copies around of the doctor's CV?
I've also been given a binder of medical records of Patricia Henley. And from quick observation, it appears to be the same content as binders previously provided in other expert depositions.
Is that the case, to your best understanding, Counsel?
MR. BARRON: It's my understanding. I did not assemble it, but I think that was the intent, and it looks that way from the index.
MS. CHABER: Okay. And at the risk of not being complete but maybe saving some trees, I'm not going to attach that as an exhibit.
And then there was a second set of records not bound that is entitled "Patricia Henley versus Philip Morris." And these are updated records of certain facilities, and appear again, without having gone through it all, to be similar to or the same set of records that had been provided, I believe, to

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Dr. Warren, and which Dr. Warren or your office then provided to me.
Is it your understanding, Counsel, knowing that you have not yourself gone through it in the same manner, that that's what this second set of records appear to be?
MR. BARRON: Yes. I think the intent is to replicate there what was Exhibit 5 to the deposition of Dr. Warren, as well as the copy of records that I provided to you that was a duplicate of Exhibit 5 at the time of Dr. Warren's deposition.
MS. CHABER: Okay. And ditto on the trees on this one. I'm not going to attach it.
And also in front of us are a series and set of x-rays and CT scans of Patricia Henley. These have appeared at various depositions to date.
Counsel, are you aware of there being any new or additional CTs or x-rays beyond what has already been seen at Dr. Warren's deposition, for example?
MR. BARRON: No.
MS. CHABER: I'm obviously not going to attach those to the record either.
Q. Dr. Rosenbach, can you tell me what you have been asked to do in this case?
A. Yes. I've been asked to review the films, the

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plain film radiographs and CTs, bone scan, and provide a radiologic interpretation.
Q. Did you also review the MRI of the brain?
A. I'm sorry, yes, I did.
Q. And did you review the medical records that

have been described previously?
A. I reviewed them.
Q. Can you give me an idea of the length of time you spent reviewing those records?
A. Oh, maybe a half an hour.
Q. Were you looking for anything in particular when you reviewed them?
A. Radiologic reports, pathology report, bronchoscopy.
Q. Anything else?
A. That's pretty much about it. I don't want to say that at a later date you're going to ask me a question and I wouldn't want to refer to them. That's specifically what I recall right now was interesting to me.
Q. Okay. And were these particular records -- for example, the radiological reports, had they been tagged by counsel or otherwise prior to your looking at the records? In other words --
A. I don't understand that question.

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Q. There's a -- I don't know, 3-inch binder of records. Were there Post-its or tags identifying certain of the records to make it easier for you to review them?
A. Not that I recall.
Q. Okay. That wasn't very nice of you guys.
Can you give me the short version of your CV?
A. It's pretty simple, actually. I grew up in New Jersey, where I went to high school. Graduated from Princeton University. Stayed in New Jersey for Rutgers Medical School.
From there I went to Richmond, Virginia for 2 years of family practice. Stayed in Richmond, Virginia for 3 years for diagnostic radiology.
Did a year in fellowship at Georgetown University Medical Center in body imaging, and moved to Tampa, where I have been since 1987.
Q. And can you tell me what type of practice it is that you have in -- first of all, have you had the same practice since 1987 in Tampa?
A. Yes.
Q. And does it have a name?
A. Drs. Sheer, S-h-e-e-r, Ahearn, A-h-e-a-rn, & Associates, PA.
Q. And the PA stands for --

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A. Professional associate -- I don't know what -- I presume that's what it stands for.
Q. Some corporation or partnership or whatever designation. Is that your understanding?
A. I'm presuming that's correct.
Q. And what type of practice is Sheer, Ahearn & Associates?
A. It's a diagnostic radiology practice.
Q. And is it associated with any particular hospital facility?
A. Yes.
Q. What facility?
A. In Tampa, University Community Hospital, which has two campuses. Brandon Hospital in Brandon, Florida; and Manatee Memorial Hospital in Bradenton, Florida; North Bay Medical Center in New Port Richey.

We staff a hospital in Gadsden, Alabama. In Kentucky, and I'm not sure which city it is; I haven't had the pleasure to be there.

And that's it for the hospitals.

Q. Okay. And do you spend your time at one or the other of these facilities?

A. Yes.

Q. And is there any pattern or frequency of your spending time at any of these facilities?

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A. I probably spend more time at Brandon Hospital than the others. And depending on the way the scheduling is done, I'll spend time at Manatee Memorial Hospital or University Community Hospital, at either one of the two campuses.

Q. Now, is this practice a for-profit practice?

A. Without being flippant, I hope so.

Q. In this day of managed care, that isn't exactly a flippant comment.

Are the hospitals that your practice is associated with for-profit hospitals?

A. I think that University Community Hospital is not, but I'm not really sure what their structure is.

Q. And what university is it associated with?

A. It's not affiliated with a university, but it's immediately adjacent to University of South Florida. And actually, I would like to append that a little bit.

I mentioned that there were two campuses or two hospitals. And one of the hospitals has an affiliation with Nova Southeastern, and has residents and medical students rotating through.

Q. And how much time do you spend there?

A. Less than I used to. Now I'm there once every other month, once every third month.

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Q. And when did this -- you said less than you used to. When did that change occur?

A. Oh, a year and a half, 2 years ago.

Q. And was there any particular reason for the lessening of your time with the medical --

A. Well, my group is a large group. Obviously, we staff several hospitals and several offices. And the scheduling requirements just change over time. So I might spend -- for instance, starting in 1999, I might wind up spending more time at a different facility.

Q. Speaking of it being a large group, can you give me an idea the number?

A. About 55 radiologists.

Q. And are all 55 owners of the business in some fashion?

A. No.

Q. Are you?

A. I don't think so, actually. We are now part of MedPartners, and I don't think I have any ownership. I don't think any of the radiologists has any ownership.

Q. You're Board certified in diagnostic radiology?

A. Yes.

Q. And that was something -- you became Board

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certified when you finished your residency --

A. That's correct.
Q. -- in 1986. Is there any kind of continuing licensure requirements? Do you have to recertify at any point in time?
A. Actually, that's two different issues. There are licensing requirements for the State of Florida. There are no -- there's no recertification in diagnostic radiology.
Q. When you were a resident at Medical College of Virginia Hospitals in diagnostic radiology, did you have any particular area of diagnostic radiology or body part area that you were specializing in or particularly interested in?
A. We were -- residency programs aren't particularly structured that way. It's kind of like going through elementary school. You go to this, you go to this, and then you go to this.
To the best of my knowledge, residency programs have requirements that we have to fulfill, and it's not -- it was not my experience that electives were offered.
Q. So you pretty much, during residency, went through the entire body vis-a-vis diagnostic radiology. That's correct?

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A. That's correct.
Q. You then did a fellowship?
A. Yes.
Q. Did that in any way have a specialty component in it?
A. Yes.
Q. And what was your specialty?
A. It's what's called body imaging.
Q. And what does that mean?
A. That's a broad term for exams that encompass cross-sectional imaging of the body, such as CT scan, MRI and ultrasound.
Q. And in specializing in body imaging, was there any particular area of the body that you were particularly interested in or specialized in?
A. No. I can't really pick out a specific organ system.
Q. For example, you weren't interested in brain and MRI imaging greater than you were in any other part of the body? That's just an example.
A. Well, actually, body imaging is kind of separate from brain imaging or neuro, which is a separate fellowship.
But really everything from the neck on down we took a look at. And the truth of the matter is, we

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scanned what we were asked to scan.
Q. And in 1986 and '87, when you were doing your fellowship, would it be fair to say that compared to the imaging equipment available today, that the imaging equipment available in 1986 and '87 was much more rudimentary?
A. Well, no, I don't think it would be fair to say that at all.
Q. Okay. And why not?
A. Because it was enough for us to make a diagnosis.
Q. Would you agree, though, that over time, for

example, CT scanning has improved such that there is greater capability of imaging internal structures from CT scanning?
A. I think that the equipment is certainly more sophisticated, and images that are generated are better insofar as demonstrating the internal structures to a greater advantage.
Q. And is that true with all the different forms of body imaging equipment?
A. I think that applies to MRI and ultrasound as well.
Q. And in your practice, do you have any -- strike that.

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When you do CT scanning, do you tend to do conventional CT scanning, or do you also have the capabilities of doing high-resolution CT scanning?
A. We can do both.
Q. And is there any generalized practice as to when you do conventional and when you do high-res?
A. It can be on a case-by-case basis.
Q. Without spending a lot of time looking at your CV, have you written any articles or papers in peer-review journals relating to the diagnostic -- the diagnosis, rather, of lung cancers?
A. No.
Q. Can you tell me how many lung cancers since you've been in practice in 19 -- since 1987, that you have diagnosed?
A. I don't know that I have actually ever specifically diagnosed a lung cancer. The diagnosis part really is in the venue of the pathologist.
Q. Do you ever have any meetings or discussions where you get together with clinicians and pathologists to conference on a particular patient?
A. Well, there are curbside consults that are held routinely in the hospital. That's a daily event. But they are of the nature, a clinician will bring a film, say, "what do you think of this," and they wish to

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review the film with you.

It would be exceptional -- and in fact, I can't even think of a time when there would be a trio of us, clinician, pathologist and radiologist, reviewing a film.
Q. Is it common practice, however, in your practice to conference with the pathologist and the clinician on a particular case to discuss commonly shared views or disagreements about a case?
A. No.
Q. And do you ever in your analyses of body imaging indicate -- well, strike that. Let me start over again.

Do you generally render reports when you have reviewed radiographs?
A. Typically.
Q. Do you generally -- if there's more than one film, for example, do you generally jot down notes of your review of the films?

MR. BARRON: Let me just object to the question as being ambiguous. I assume you're talking about in a patient diagnosis and treatment setting, as opposed to medical-legal?

MS. CHABER: Q. I'm talking about in your practice since 1987, when you review films that are a series or radiographs that are a series rather than one discrete individual film, do you tend to take notes as you review them?

A. No.

Q. Do you dictate what you're seeing as you review them?

MR. BARRON: Objection. Vague and ambiguous as to the setting and circumstances that you're asking about.

THE WITNESS: If you're referring to my practice in the hospital, when I see a film that represents the last film of a series of films, I typically generate a report. Or actually, I dictate my findings, and hopefully transcription generates a report.

MS. CHABER: Q. And in your practice when you generate reports based on your findings from reviewing radiographs, do you ever ascribe a diagnostic condition, or do you only report objective information?

A. Well, that's a very broad question. And of course, there are occasions when I feel very comfortable making the diagnosis.

For instance, fracture. That's a diagnosis. And I feel very comfortable making that diagnosis. If only all of medicine were so straightforward.

So many, many times, probably the majority of times, I am unable to make a definitive diagnosis.

Q. And in those times when you are unable to make a definitive diagnosis, do you give a differential diagnosis?

A. Sometimes.

Q. And have you ever given a differential diagnosis in reviewing radiographs of an individual where the differential was lung cancer versus thymic cancer?

A. Have I ever?

Q. Yes.

A. I don't know.

Q. Have you ever given a diagnosis, differential or straightforward suggestion, of a thymic cancer?

A. I don't know that either.

Q. In reviewing radiographs in your practice, have you ever given a -- rendered a report where after your objective conclusions, you stated something to the effect of, "suggestive of lung cancer"?

A. Well, let me say that I don't know that I've ever said "suggestive of lung cancer," to answer that specific question.

But sometimes you say, "diagnostic possibilities include," whether it's thymic neoplasm or a lung neoplasm.

My experience is that offering a solitary, definitive diagnosis in radiology is hazardous.

Q. And why is that?

A. Because you don't know whether or not you're right.

Q. And in those instances when you don't know whether or not you're right based on what your

interpretation is, do you ever meet with the clinician to discuss clinical findings in combination with your analysis?
A. Sometimes, although it doesn't necessarily help. The films are the films. And then to me, the diagnosis rests with the pathologist, the one who looks at the tissue.
Q. Have you ever rendered findings where it was your belief that one of the possibilities of what you were seeing was a thymic cancer?
A. I actually think that you asked me this moments ago, and I might have said I don't know. And I'll tell you that I've been practicing radiology for a long time, so it's hard for me to say no. "Ever" is pretty encompassing.
When there's a mediastinal lesion, sometimes you suggest the possibility of a thymic lesion. And

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since I'm sure that I've seen mediastinal lesions, I've suggested that a thymic neoplasm is a possibility.
Q. Do you know on how many occasions you have done that?
A. No.
Q. Have you ever on any occasion where you have done that followed up to determine what the actual diagnosis was, either from the pathological viewpoint or the clinical viewpoint?
A. It's always an intellectual curiosity what something is, although unfortunately, private practice isn't necessarily structured in a way that gives you the feedback that you'd like to have.
Nevertheless, I'm sure over the course of my career I've found out this was this and that was that.
Q. Do you have any memory with respect to finding out that a suspicion you had of a thymic cancer turned out to be a thymic cancer?
A. No.
Q. Do you know how many thymic primary cancers have been identified in the world's literature to date?
A. No, I do not.
Q. Do you know how many primary thymic cancers in the world literature of a small-cell variety have been diagnosed to date?

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A. No.
Q. Do you know whether it is a common disease or a rare disease?
MR. BARRON: Excuse me, vague and ambiguous as to what, quote, "it" is, closed quotes, since you've mentioned a couple in the past questions.
MS. CHABER: Q. Small-cell thymic carcinoma.
A. I would suspect it's unusual.
Q. Have you read any articles at all in connection with any opinions you're going to render today?
A. No.
Q. Have you had discussions with attorneys for Philip Morris as to any testimony that either has been given or will be given by other experts in this case?
A. No.
Q. Have you read any reports written by any retained experts in this case?
A. I saw a synopsis of Dr. Feingold's

interpretation of a CT scan.
Q. And where and when did you see that?
A. Yesterday, in this room.
Q. And do you have that in the materials that you have provided?
A. I'm not sure.

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MS. CHABER: Counsel, could you provide that, please, or show it to the witness?
MR. BARRON: I wasn't here, so I don't know what he was shown. I assume what he was shown was what he just described, which was that portion of the report that you provided that had the chest and plain film and CT interpretations.
But why don't you -- I don't have it with me. Why don't you show him and ask him.
MS. CHABER: There are three other lawyers here, at least one of whom was present yesterday.
Q. Who did you meet with, by the way, that showed you this synopsis?
A. Mr. Perry -- Jane, I'm sorry, I don't remember your last name, and not to be offended, it's not a sexist thing -- Pat, and I don't recall his last name.
Q. Mr. Sirridge? Pat Sirridge? Does that sound familiar?
A. I really don't know. I'm very bad with names.
Q. But at least two of the people who showed you whatever this synopsis is are sitting in this room now?
A. To the best of my recollection.
MS. CHABER: Counsel, can we not play games, please? You've got two counsel here. If you want to take a break and ask them what it is that they showed

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him and provide it to me, that's fine.
MR. BARRON: I don't mind --
MS. CHABER: But to say you don't know because you weren't here when there are two other people who were present is a bit game playing, don't you think?
MR. BARRON: Let me make a suggestion to you.
Number one, don't rush to be offended. It's unnecessary. Number two, please don't use pejorative terminology like that when it's uncalled for.
I responded to your question. I don't really have to respond to questions. I'm trying to cooperate.
I was trying to shorten it up. I'm happy to take a break and find out exactly what portion of the report he was shown. I don't mind doing that.
But I don't like to do it in response to the way you request it. So I would ask in the future that you think it through a little more clearly before you do what you just did. Okay? So we can get along in a nice way that the Court likes two lawyers to get along. Okay? Thank you.
MS. CHABER: And that would be fine, and particularly if you, Counsel, wouldn't -- would consult with the other counsel --
MR. BARRON: I'm taking a break right now.
MS. CHABER: -- with the other counsel there.

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That's fine. We can go off the record. Please find out what it was.
(Recess from 9:46 a.m. to 9:54 a.m.)
MS. CHABER: Q. Dr. Rosenbach, before we go

on to other matters, my office has kindly sent over a check for this deposition.

Is your fee $600 an hour for deposition?

A. That's what my firm charges.

Q. That's what --

A. What my firm charges.

Q. And what do you charge for consultations with attorneys?

A. $350 an hour.

Q. And does this money that you get from expert consultations or expert depositions, is this money that goes into your clinical practice?

A. It goes to MedPartners. I'm on salary.

Q. Handing you a check for $1200, which represents 2 hours of time. We'll see if we have to go beyond that.

I've also been given what appears to be page 13 of Dr. Feingold's report.

Before the break, we were -- you were making reference to a summary that you looked at of some radiographs. Is that the summary?

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A. This is the summary.

Q. Okay. And was it only one page like that?

A. There were more pages. I did not see them. This was the only thing that I saw.

Q. And was the highlighting your highlighting, or was that highlighting already on?

A. It was already there.

Q. And at the time that you reviewed this, were you given any specific information about why you were being asked to review this?

A. Review this sheet of film, paper?

Q. This 13 -- yes.

A. I was asked if I thought there was thymic tissue, residual thymic tissue on the CT scan of January 3, 1998.

Q. And this had not been a question that had been asked prior to your review of page 13 of Dr. Feingold's report. Is that --

A. No; it fact, it had been.

Q. And what had been your answer at that time?

A. I did not appreciate any residual thymic tissue.

Q. And subsequent to your review of page 13 of Dr. Feingold's report, are you of the same opinion as just stated?

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A. I do not see any residual thymic tissue.

MS. CHABER: I'll attach this page. And I know sometimes yellow highlighting doesn't show up, but if somehow we could copy that so that it does. And that would I guess be Plaintiff's second.

Q. When were you first contacted by anyone with respect to the Patricia Henley case?

A. Several months ago.

Q. Can you be a little more specific?

A. 3, 4, 5 months ago.

Q. How were you contacted?

A. Curtis Perry asked me to review the films.

Q. And did you know Mr. Perry before this date?

A. Yes, I did.

Q. And how?

A. He has asked me to review films on previous occasions.
Q. And who do you understand Mr. Perry to represent?
A. He is a lawyer with Shook, Hardy and several other lawyers.
Q. And who do you understand Shook, Hardy to represent?
A. Philip Morris.
Q. And while you're out here, do you continue to

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be on salary?
A. I don't understand the question.
Q. I think when I asked you earlier about the expert fee that I was paying to you, you indicated that that expert fee would go to your group?
A. That's correct.
Q. While you are here present in the deposition and testifying in this deposition, are you on salary?
A. I hope so, because I would like a paycheck at the end of the month.
Q. Do you get any kind of credit or recognition for having generated additional fees due to expert testimony?
A. No.
Q. And how is it that you determine or set the amount of your hourly charge for deposition?
MR. BARRON: Asked and answered.
THE WITNESS: It's what my group charges. I don't -- it's just what my group charges.
MS. CHABER: Q. On how many occasions have you consulted with lawyers for Philip Morse?
A. Well, I don't know that I can answer that question.
Q. And that is because --
A. I don't know if they're represented -- I can

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tell you how many times I've met with Shook, Hardy, and that's somewhere between 15 and 20 times.
Q. And how many times have you reviewed radiographs for Shook, Hardy?
A. Between 15 and 20 times.
Q. Each of those consults resulted in your looking at films?
A. Yes.
Q. And on how many occasions have you rendered any kind of report in connection with your review of radiographs for Shook, Hardy?
A. I don't think I've rendered any reports.
Q. How many times have you testified in a deposition at the request of Shook, Hardy?
A. Today makes number three.
Q. And what are the other cases that you testified in?
A. Engel, and -- I'm not exactly sure how to pronounce this person's names. Brush, or Bruch.
Q. Do you know how to spell it?
A. You know, I said I'm bad with names. It's B-r-u something. A "sh" sound.
Q. C-h or something?
A. Something like that.
Q. And was that Engle, E-n-g-l-e?

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A. Either l-e or -e-l. I'm sorry, seriously, I'm bad with -- we have our strengths and weaknesses. There is one of my weaknesses.
Q. Was the Engle a particular case involving an individual named Engle?
A. He was an individual. I think it was a class action suit.
Q. And have you been asked to testify in court in that class action suit?
A. Not to date.
Q. Well, today you're here. Up to --
A. In that case -- I'm sorry if I misunderstood the question. I believe --
MR. BARRON: You didn't. She didn't hear your answer. You said, "not to date."
MS. CHABER: Oh, "to date." I thought you said, "not today." Okay. You are correct, I did not hear him.
Q. Do you understand that you will be asked to testify in that case?
A. I have no idea.
Q. And when was that deposition in the Engle case?
A. 9, 12 months ago.
Q. And in the Bruch or however you pronounce the

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-- that other, when was that deposition?
A. It was either last week or the week before.
Q. And where was it?
A. In Tampa, Florida.
Q. Was it by telephone or in person?
A. Some of it was by telephone. I was in person.
Q. Was the person taking the deposition of you on the telephone?
A. Yes.
Q. Do you know the name of the person who was taking the deposition of you?
A. I'm just bad with names. It begins with a W.
Q. Mr. Wilmer?
A. Yes, thank you.
Q. And is it Mr. Bruch, or Ms., or Mrs.?
A. It's a female.
Q. And do you know what the disease that was claimed to be or alleged by the plaintiff in that case -- do you know what that was?
A. It was alleged to be a lung cancer, with metastatic disease.
Q. And did you diagnose it, or determine that it was a lung cancer?
A. No.
Q. And do you know what the disease claimed or

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alleged to be in the Engle case?
A. No.
Q. Do you recall what your opinion was in that case?
A. No.
Q. Can you tell me what the normal thymic gland looks like? Can you describe it?
A. You're going to have to be more specific than that.
Q. How about, at age 1, what does the normal thymic gland look like?

A. You're still going to have to be specific. Do you mean under gross examination or in radiography? Because if you mean gross, I can't tell you.
Q. Okay. Give me the appearance radiologically.
A. It looks like a soft tissue opacity in the mediastinum, and it's quite plump, typically, in healthy children.
Q. Do you have a size range?
A. No. It's an eyeball type of thing.
Q. Can you approximate a size range?
A. No, not really.
Q. And with respect to my questions about the description or appearance of the thymic gland in a normal individual, would it be fair to say that at all

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ages you would be unable to give a gross description of it?
A. The gross --
MR. BARRON: I just need to object to the form of the question as being ambiguous, when you say, quote, "gross description," close quote.
MS. CHABER: Q. I thought I used your terminology, Doctor.
A. Well, I'm a radiologist, and I can't tell you what it looks like. If you put a thymus in front of me, I can't tell you. If you put a film in front of me, that's my area of expertise.
Q. Okay. Can you give me a description -- so I wanted to shortcircuit this by understanding that when I'm asking you for a description at various ages, that I'm asking radiographically, since you are unable to give me the information grossly.
Is that a fair understanding?
A. That's a -- that's the only way I can answer the question.
Q. Okay, great.
Can you tell me what the normal thymic gland looks like at age 10?
A. Well, it's a soft tissue opacity that's kind of triangular. And if -- remember the old Star Trek

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series, they wore that little badge that was kind of perimetal? That's kind of what it looks like, at least on cross-sectional imaging.
Q. And can you give an idea of relative size?
A. Smaller than at age 1.
Q. And at age 30, can you describe the thymic gland, a normal thymic gland?
A. I'm not sure that I can or anybody can. The thymic gland involutes. It goes away over time, and I'm not sure that a typical 30-year-old is going to have any appreciable thymic tissue that's demonstrable on radiography.
Q. And that would include on CT scan?
A. Yeah. That's correct.
Q. And would it be your opinion that there would be no appreciable thymic gland visualized -- normal thymic gland visualized in a 30-year-old on high-resolution CT scanning?
A. Well first of all, you know, one 30-year-old is different from another 30-year-old.
The natural history or evolution of the thymic gland is that it's going to involute. It's going to go

away. And I'm not sure that high-resolution CT is going to show something that might not be there on an individual.

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Q. At what age do you believe that there -- in a typical, normal thymic gland, it would have involuted to the point of not being able to be appreciated on a high-resolution CT scan?

A. Well, I'm not really sure that I can answer the question. I haven't really done an exhaustive study or even a superficial study, because typically we don't look to see what's happening to the thymic gland, whether with high-resolution CT or non-high-resolution CT.

But it's my general guesstimate that by 40 with any kind of CT scan I would be surprised to see any residual thymic tissue or normal thymic tissue in -- unless it's a variant.

Q. Why is it that you indicated that you don't look to see what's happening with the thymic gland?

A. Because it typically goes away.

Q. In reviewing Ms. Henley's radiographs, did you see any evidence of markers of cigarette damage?

A. I think you're going to have to be more specific.

Q. Do you believe that a diagnostic radiologist can review radiographs and see evidence of disease -- well, strike that. Let me get some foundation here for a minute.

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Do you believe that cigarette smoking can cause any type of disease that can be visualized radiographically?

A. I think that cigarette smoking is associated with diseases that can be visualized radiographically.

Q. And what do you mean by "associated," Doctor?

A. I mean that in a given population, patients who smoke have a greater incidence of a disease than a nonsmoking population.

Q. Do you believe that there is any disease that is caused by cigarette smoking?

A. I'll tell you, that's way too broad for me to answer.

Q. I asked you if you believed that there was any type of disease that can be caused by cigarette smoking.

A. You know, the spectrum of pathology in the human body is vast. And whether or not somebody can say, this is caused by that, I'm not in a position to argue as a radiologist. I do not have an encyclopedic knowledge of pathology nor the epidemiology of disease.

My statement was, I believe there are some things that are associated with cigarette smoking. I'm not prepared or competent to judge whether or not it's caused by cigarette smoking.

Q. Let's limit my question from the broad to the

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lungs.

Do you believe that there are any diseases of the lungs that can be caused by cigarette smoking and seen radiographically?

MR. BARRON: Hold your answer for a minute.

I'm going to object on the basis of discovery relevance. I understand what you want to do, I

understand the reasons why you want to do it, and you've done it in every deposition.

I would suggest you go to the opinions that he has on the issue of neoplasm, mass or whatever we deal with in terms of the radiological studies that he did. Then you and I maybe can debate this issue.

But in light of the time that we have available and everything else, I think that's a more productive way to use the time, and I'm not convinced that this is of discovery relevance at this point.

MS. CHABER: Q. Doctor, do you believe that there are any diseases of the lung that can be visualized radiographically that are caused by cigarette smoking?

MR. BARRON: Okay. Let's take a break. I want to find out -- I want to get some counsel on this from some people who have dealt with these issues in discovery with you and in other cases. I'm just,

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frankly, I will tell you, not familiar with whether we're going to allow this. We may. I just want to discuss it first.

I made a suggestion which would get us through some other material; we can get back to this. You don't want to apparently do that at this time. So let's take a 5-minute break, and I'll come back and give you an answer.

MS. CHABER: And I think it's highly inappropriate, Counsel, for you to tell me how I should be conducting my deposition when you've offered somebody as a radiologist with respect to lungs and radiological analysis.

I'm entitled to explore his opinions as a medical doctor as to what he thinks may cause the things that he sees on radiographs. And I suggest, Counsel, that you make this break short, because I'm prepared to go forward, and I understand that you want to get this doctor out of here today on an airplane.

MR. BARRON: I haven't made a final decision. I said I want to just get some advice on it, and we'll get right back to you.

Take a break, and I may let him go forward with it, if you want to spend your time right now on that issue. Let's take a couple minutes. Okay?

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MS. CHABER: Tell you what. I'll go on and ask a couple of others, because you may need to consult with other counsel -- why don't I get them out now so we don't have to take a break every 3 or 4 minutes to decide?

MR. BARRON: I'll let you do that. I will tell, you if it's along the same lines, I think I know where you're going, so you don't have to do that for my benefit. If you want to do it, you can go ahead and do it.

MS. CHABER: Q. Doctor, do you believe that cigarette smoking causes emphysema which can be radiologically seen in an individual?

MR. BARRON: It's the same line of questioning, because you're emphasizing the word "cause." And you know what you're doing and I know what you're doing. So let's take a break, and we'll find out whether we want to spend our time this way or not.

Okay? Couple minutes.
You can stay right here.
(Recess from 10:18 a.m. to 10:27 a.m.)
MS. CHABER: Do you have a decision, Counsel?
MR. BARRON: Sure. If you want to do that, you certainly can do that.
THE WITNESS: Could you read back my last

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question? Actually, my last three questions before the break?
(Record read.)
MS. CHABER: Back on the record.
Q. Doctor, do you believe that there are any diseases that -- disease or diseases that cigarette smoking causes that can be seen radiographically in the lung?
A. Obviously, the operative word here is "causes." And I have already stated under oath here that I'm not prepared or competent to say what is caused by what, by cigarette smoking.
Q. What is your definition of "cause" in a medical sense?
A. Well, I don't know that it's specific to medicine. The word "cause" to me is -- cause.
Cause. Something has a cause and effect. If we can say that cigarettes by themselves are singlehandedly responsible for smoking -- I don't know what Webster says about cause. But to me, it's an agent that by itself results in some event.
Q. And do you believe that the term "cause" cannot be used with respect to disease and cigarette smoking?
A. I don't know.

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Q. As you've defined the term?
A. As I define it, I am not prepared to say that cigarettes cause those diseases.
Q. All right. Are you familiar with the Surgeon General's 1964 report on cigarette smoking?
A. I know he had it, but I'm not -- I mean, I know it's there. I'm not intimately acquainted with it.
Q. Have you ever read it?
A. No.
Q. Have you ever read the 1989 report of the Surgeon General, Reducing the Health Consequences of Smoking - 25 Years of Progress?
A. No, I have not.
Q. Let's assume that the Surgeon General uses the following definition of "cause."
"The notion of a significant effectual relationship between an agent and an associated disorder or disease in the host."
Can you accept that definition?
MR. BARRON: I think as a matter of courtesy, you ought to let him see it, let me see it. I think it's hard for anybody to be confident that they are getting it all when you just read something that long and complicated.
MS. CHABER: I'm asking him to make the

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assumption --
MR. BARRON: I got the assumption part. I just said, as a matter of courtesy, if you don't mind,

we'll photocopy it and he can look at it, or you can provide it -- hand it to him and let him read the section so we all know exactly what words you're using, that's all.

If you don't want to show him that courtesy, don't be courteous to him then.

MS. CHABER: It's not a question of courtesy, Counsel. It's a question of conducting the deposition in the fashion I wish to, similar to the way Mr. Ohlemeyer takes quotes out of the middle of articles and asks whether someone agrees or disagrees.

THE WITNESS: I'll make it simple. I'd like to see a copy of it, please. And I believe I'm entitled to see a copy, just because I can't remember everything you're telling me.

MS. CHABER: Q. Let me ask you to assume the following definition of the word "cause."

"A significant effectual relationship between an agent and an associated disorder or disease in the host."

A. Could you read that one more time, please?

Q. Yes. "A significant effectual relationship

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between an agent and an associated disease or disorder in the host."

MR. BARRON: I'm going to object to the question as now being vague and ambiguous. I'm not sure what you're asking him.

I also specifically object to the terminology of, quote, "significant effectual relationship," close quote, because you haven't defined it. I'm not sure if the Attorney -- or if the Surgeon General has defined it, and if so, what that definition is. And you are taking an isolated part of a large report, perhaps out of context.

THE WITNESS: What was the question?

MS. CHABER: Q. Can you -- do you agree with that definition of the word "cause"?

MR. BARRON: Objection.

THE WITNESS: Well, that's -- I'm sorry.

MR. BARRON: Go ahead.

THE WITNESS: Yeah, that's what the Surgeon General defines it for himself. I have to agree that it is somewhat ambiguous, depending on what "significant" and "effectual" means.

You know, that's the way he defined it.

MS. CHABER: Q. Can you agree with that term or not?

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MR. BARRON: Objection. Ambiguous as to, quote, "can you agree with that term or not," close quote. From what point of reference are you asking him?

MS. CHABER: Q. Can you agree with the definition, Counsel, of "cause" as stated and as I have read now four times?

MR. BARRON: Again, it's -- I'm going to object. I don't understand the phrase, quote, "can you agree"? From what point of view, what perspective?

MS. CHABER: Q. As a medical doctor, can you agree with the definition of the word "cause" to be "A significant effectual relationship between an agent and an associated disorder or disease"?

A. How significant is "significant"?

Q. However significant you want it to be. Is that your qualifier?
A. Well, to me, a cause is a direct event or antecedent.
Q. Something that occurs beforehand?
A. Well, a lot of things could occur beforehand. A cause to me means, something happens; and as a direct consequence of that, and that event only, something happens.
Q. Is it the "only" part that is what your quibble is with that?

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MR. BARRON: Objection. The word "quibble" is argumentative.
THE WITNESS: I don't know if it's the word "only." But to me, it's directed.
MS. CHABER: Q. Are you able as a medical doctor to determine etiology of any disease or process that you view radiographically on CT or x-ray?
A. Yes.
MR. BARRON: Sorry --
MS. CHABER: Q. And what are you able to determine etiology on when we're talking about the lungs?
A. Well, that's something entirely different from what you just asked me.
Q. Well, I'm limiting it now.
A. I'm not sure about the lung. That's a little bit more problematic.
Q. Are there any disease or diseases, conditions of the lung, which you are able as a medical doctor to determine etiologically?
A. Yes, I think so.
Q. And what disease or disorders?
A. Pneumonia.
Q. And what is the etiology of pneumonia?
A. Well, that's -- actually, it's a good

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question. Presumably, it's bacterial or viral.
Q. Anything else?
A. And for a specific diagnosis, no, I can't tell you what the etiologic agent is.
Q. But you accept that there is some agent that has resulted in a pneumonia, whether it be bacterial or viral?
A. In general, that's right, yes. The problem is, I'd also add that it's not necessarily specific. A chest x-ray doesn't absolutely tell us that there's a pneumonia. It tells us that there's a process in the lung, and we're speculating maybe that it's a pneumonia.
Q. And you correlate that with clinical findings?
A. Well, the clinician does.
Q. What are the etiologic causes of bullous emphysema?
A. I would defer to an epidemiologist.
Q. Have you as a medical doctor and radiologist ever radiologically described emphysema?
A. I don't use the word "emphysema," actually. I say there are bullous changes in the lungs, or that there's evidence for a COPD.
Q. And what is COPD?
A. It's an abbreviation for chronic obstructive pulmonary disease.

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Q. And what is the characteristics or evidence that would cause you to say there is COPD?
A. Hyperinflation of the lungs. You can have bullous changes.
Q. Can cigarette smoking cause bullous changes in the lung?
A. Here we get to the cause question, and I don't purport to be an expert on the causation.
Q. Do you know any process by which there might be a cause-and-effect relationship between the inhalation of cigarette smoke and bullous changes of the lung?
A. Do I know the pathophysiological processes? No, I do not.
Q. And what are the cause or causes of chronic obstructive pulmonary disease?
A. I'm not sure what all the processes are.
Q. Do you know any?
A. Well, it gets back to what "cause" is. Now, as President Clinton says, what is "is"? It's not quite as simple. But what causes it -- there are things that are associated with it.
Q. In a 100-pack-year smoker who has smoked two to three packs of cigarettes a day and demonstrates bullous changes in the lung, do you have an opinion,
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sir, as to what would be the cause of that person's bullous changes in the lung?
A. Well, we still go back to cause. And I said that there were certain diseases that I thought were associated with cigarette smoking. And so I -- if you're asking me that, I would say, well, I suspect that the cigarette is a contributory agent.
And again, when I say that, I say that only with, there's an association along with, I don't know what ever else, so "contributory" might not be the best word.
But cigarette smoking can be associated with COPD. So, you know, it's kind of a leap to say that the cigarettes had to cause it. I don't know that I would say that.
To me, it's just -- there's an association, I guess, is really what I'm trying to say.
Q. I didn't ask you if they had to cause it. I asked you, can they cause it?
A. Well, "cause" again -- to me, having to and can and being able to, they're quite different semantically. But we still get back to cause. And "cause" to me is the key word here, and I'm not a causation expert.
Q. Doctor, in a person who has a 100-pack-year
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history of cigarette smoking who presents with a massive left hilar abnormality and some densities in their chest, what would your differential diagnoses be in reviewing radiographs of that individual?
MR. BARRON: Please hold your answer.
I'm going to object to that question as, first of all, ambiguous and imprecise. For example, the use of the phrase, quote "some densities," close quote. Therefore, it becomes, in my view, an improper hypothetical.

And it also is a hypothetical that doesn't contain enough predicates to allow an answer, especially since he's not seeing the films that you are hypothesizing in this question. And I'm going to have the same objection to any other line of questioning in that regard.

So I will just not repeat all this. I'll just keep saying "same objection," unless I have to make it more precise for the particular objections that follow.

MS. CHABER: Q. Can you answer the question?

A. No. What densities were you talking about?

Q. A density in the upper lobe.

MR. BARRON: Same objection. What type of density? You haven't described size, how it's seen radiologically or anything else. I think it's an

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improper hypothetical.

THE WITNESS: You know, with a broad question like that, it could be any one of a number of things. Neoplastic, inflammatory, infectious, metabolic -- I wouldn't necessarily favor that. Connective tissue disease.

MS. CHABER: Q. Let's assume you're given a chest x-ray, Doctor, and you know nothing more about the patient than there is a massive left hilar abnormality, and the person has 100-pack-year history of cigarette smoking.

What are the differential diagnoses that you would give at that point in time based on that information?

MR. BARRON: Please hold your answer.

Again, I'm going to object to the question as being an improper hypothetical. It's vague and ambiguous when you say, quote, "massive left hilar abnormality," close quote.

And it's a hypothetical that in my view wouldn't contain enough predicates to allow a reasonable response, and I will object to it on that grounds.

THE WITNESS: Differential diagnostic considerations include neoplasm, inflection, inflammatory. I was going to say, occupational

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exposure. I still don't like metabolic. But something like some autoimmune type of process.

MS. CHABER: Q. Are there any findings that you consider to be pathognomonic of a small-cell lung cancer?

A. I can't think of any off -- I mean, I can't think of any.

Q. Are you familiar with the textbook by Frazier and Pare?

A. I'm familiar with it.

Q. Is that a book that you consult?

A. On occasion.

Q. Do you recognize it as an authoritative text on radiologic diagnosis of diseases of the chest?

A. Well, if by "authoritative" you mean do I believe every word that's in there, no, I don't consider it authoritative.

If you mean do I refer to it and find some value in the information that's there, yes.

Q. I would assume that there would be no textbook that would come to mind that you would indicate was

authoritative if the definition was you agreed with every word of it. Is that true?
A. That's true.
Q. But it is a book that you do consult and refer

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to?
A. On occasion.
Q. And what other texts do you consult and refer to?
A. In all of radiology?
Q. Let's limit it to diseases of the chest.
A. There's a six-volume loose-leaf binder called Radiology. Simple things like Paul and Jewell. I'm sorry -- Paul and Jewell.
Q. Jewell, as --
A. Jewell. I don't know how to spell it. Freundlich, F-r-e-u-n-d-l-i-c-h, with one of those umlauts on it, a text -- just a text. I don't know -- and various -- again, I can't -- again, I am bad with names, but I can show you where they are.
Q. Do you consider yourself an employee of your -- I don't want to use the wrong terminology. Employee of your --
A. I guess so.
Q. -- radiologic facility?
A. It seems to be right.
Q. And I think you indicated there are about 55 people associated with this organization?
A. That's about right.
Q. And are they all employees, or is there a

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single or a few doctors that are considered the employers?
A. Everybody is an employee.
Q. And have you discussed with any of your fellow -- and by that I include the feminine, for lack of better terminology -- have you had any discussions with any of your fellow employees regarding the Henley matter?
A. No.
Q. Have you had any discussions with any medical personnel with respect to the Henley matter?
A. No.
Q. Have you had any discussions with any of your fellow employees about your consultation or testifying on behalf of cigarette companies?
A. I'm sorry, what was the question again?
MS. CHABER: Could you read it back?
(Record read.)
MR. BARRON: I'm going to object to the form of the question as being argumentative with the phrase, quote, "on behalf of cigarette companies," close quote.
THE WITNESS: Some people. But I don't think everybody in my group knows that I do consultation work on cases brought to me by Shook, Hardy.
MS. CHABER: Q. Do they know, these people

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who are aware that you do consultation work on behalf of Shook, Hardy, that you are doing so because Shook, Hardy is representing a cigarette company?
A. I'm sorry, that question doesn't make any sense to me.
Q. You understand that you are here, sir, in a

case where Philip Morris is the defendant. Correct?
A. I understand that.
Q. And you understand that Shook, Hardy helps Philip Morris?
A. Yes, I do.
Q. And you understand that Philip Morris is a cigarette company. Correct?
A. It's -- among many of its other functions as well, I think. Doesn't Philip Morris do a lot of other things besides cigarettes? But yes, they do cigarettes.
Q. I go back to my question, then.
Do any of your fellow employees know that you are consulting with attorneys on behalf of a cigarette company?
MR. BARRON: Same objection to the phrase "on behalf of a cigarette company" as being argumentative.
THE WITNESS: They know that I am looking at films brought to me by Shook, Hardy, and that those films -- and that Shook Hardy -- or I don't know per se

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they know Shook, Hardy, but they know that those films were brought to me by a law firm that represents a tobacco company.
MS. CHABER: Q. And how many of your fellow employees would you say know that?
A. I couldn't tell you. Somewhere less than 55.
Q. More than five?
A. Probably, yeah.
Q. Let's turn to the Henley case.
When was the first time you looked at the x-rays?
A. 4, 5 or 6 months ago.
Q. Were they brought to you accompanied by attorneys?
A. Attorney.
Q. And that was Mr. --
A. Perry.
Q. -- Perry. And at the time that you reviewed those films -- first of all, do you know whether it was all the films that we see here today, or did you see additional films along the way?
A. I believe I saw less than -- or fewer than all the films that are here today.
Q. And at the time that you reviewed the films in this first meeting with Mr. Perry, did you dictate or in

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any way make any notes of what your review of the films were?
A. No.
Q. Did he?
A. Did he?
Q. Yes.
A. I believe he made notes.
Q. On how many different occasions have you reviewed chest radiographs or other radiographs in this case?
A. Twice. Twice.
Q. And the first time was 4 or 5 months ago?
A. Yes.
Q. And when was the second time?
A. Yesterday.
Q. And when you reviewed them yesterday, it's your belief that there were more radiographs than you

had seen previously?
A. Yes.
Q. And did you dictate any notes or impressions of your reading of the radiographs?
A. No.
Q. How many lawyers were in the room when you were doing that yesterday?
A. Four.

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Q. How long was this review yesterday?
A. Oh, it stretched out over maybe 3 hours.
Q. And other than being shown the page that we've marked as Plaintiff's Exhibit 2, were you given any other information, either orally or in writing, about what any other experts' opinions were with respect to the radiographs?
A. No.
Q. Why don't you give me a summary of what your opinions are with respect to Ms. Henley.
MR. BARRON: I'm going to object to the question as calling for a narrative and being too general.
As we have in previous depositions, I will allow him to answer as long as we have an understanding that he's giving a general overview, brief summary of his opinions, and not every subopinion that he might have.
MS. CHABER: Q. Go ahead.
A. My opinion is that Ms. Henley had a chest radiograph and a CT of the chest on January 3, 1998 which showed a mediastinal and left hilar soft tissue opacity that measured approximately 6 centimeters.
Q. Any other opinions?
A. That's pretty much about it. I mean, if you

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want to get specific about things, I don't really know -- you know, she had subsequent exams. She had a subsequent CT scan which showed change. She had radiation and chemotherapy.
Q. And what type of change was shown?
A. The mass either -- well, the mass shrunk down quite considerably, maybe to the point of absence. It looks like there's maybe some scar where it was.
Q. Do you have an opinion what caused the scar?
A. Well, probably the intervention, whether that relates to the radiation, the chemotherapy, or possibly even her mediastinoscopy.
Q. Did you see any evidence of any densities in the lungs?
A. There was some hazy opacities in the lung that was adjacent to the lesion, and also some hazy opacity in the left lower lobe.
Q. Did you see any changes that you would describe as COPD?
A. I saw some very mild changes that looked like some very mild bullous change.
Q. Now, do you have an opinion as to what the mediastinal -- I don't remember if you said mass --
A. I said lesion.
Q. Lesion. Do you have any opinion as to what

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the mediastinal lesion, the left hilar -- did you use the word "mass" then? I didn't get it all down.

A. I don't know if I used the word "mass." There's a soft tissue opacity, which is actually what I prefer to use, because that's what it truly is on the radiograph.
Q. And what do you believe that soft tissue opacity is?
A. Well, it could be neoplastic, it could be inflammatory. It's not specific on the radiograph.
Q. When you say the radiograph, are you referring to both the x-ray and the CT scan?
A. I'm sorry. Yes, I am.
Q. And can you tell me what film you're referring to that you saw some hazy opacities in the lung adjacent to the lesion?
A. The CT scan.
Q. The --
A. 1-3-98.
Q. And do you have an opinion as to what those hazy opacities in the lung adjacent to the lesion represent?
A. Well, I suspect that it's from some atelectasis.
Q. And what would be the cause of that

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atelectasis?
A. Well, in the lung relating to the opacity, I think it's compressive. The lung is being pushed aside, and it's probably resulting in some mini collapse or atelectasis.
And I'm not sure about the left lower lobe. I think that's probably atelectasis, too, although why it's there, I'm not sure.
Q. The hazy opacity in the lung adjacent to the lesion, was that in the left upper lobe?
A. Yes.
Q. And whatever the hazy opacity was, was it actually in the parenchymal tissue?
A. I think so, yes.
Q. And is a potential explanation for a hazy opacity in the lung a neoplasm?
A. Well, you know, unfortunately, nothing's absolutely specific.
Is it a potential explanation? I think everything's a potential explanation, although I wouldn't necessarily favor it, but -- I really wouldn't favor that.
Q. Is it a reasonable differential?
MR. BARRON: Objection as to the phrase, quote, "reasonable differential," close quote, being

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ambiguous.
THE WITNESS: I wouldn't offer it.
MS. CHABER: Q. Am I correct that you have no analysis as to what the hazy opacity in the left lower lobe represents?
A. No. I suspect that that is probably some atelectatic change as well.
Q. And what caused that?
A. I already said, I'm not sure.
Q. Would that atelectatic change be due to some type of compression in the left lower lobe?
A. I don't think so.
Q. And in the left upper lobe where you talked

about I think it's atelectasis due to some compression, what would be causing that compression?
A. Well, it's -- that area is immediately adjacent to the mediastinal and hilar soft tissue opacity, and that's what causing, I think, that compression.
Q. And the soft tissue opacity that you saw, that was approximately 6 centimeters?
A. (Witness nods head.)
Q. I'm sorry, you have to answer with voice.
A. I'm sorry, I thought you said, "in that." I didn't realize it was a question.

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Yes it's approximately 6 centimeters.
Q. And the 6-centimeter soft tissue opacity was in the left hilum?
A. And middle mediastinum and wrapping into the anterior mediastinum.
Q. And with that information of the 6 centimeter soft tissue opacity in the left hilum and mediastinum, what would you tell your colleagues in a clinical setting was the most likely diagnosis?
MR. BARRON: Objection. Number one, I think it calls for speculation. Number two, it is a hypothetical, and it doesn't have enough predicates, it seems to me. And it's ambiguous when you say, quote, "in a clinical setting," close quote.
THE WITNESS: I'd tell them that there was a soft tissue opacity there, and we've already gone through it. It could be neoplastic, it could be inflammatory or infectious, and they need to find out what it is.
MS. CHABER: Q. And having reviewed all the radiographs in this case and the records that you've reviewed, have you concluded what Ms. Henley is suffering from?
A. A neoplasm.
Q. And a neoplasm of what?

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A. Oh, that I'm not sure.
Q. What are the possibilities? Or what would be the differentials?
A. Oh, lung, thymus. You know, I'm not really sure what something in the mediastinum that has small-cell tissues in it -- I'm not sure, and I would -- you know, I would like to think that a pathologist would know more what can grow in the mediastinum that has small-cell.
Q. Can a small-cell lung cancer grow into the mediastinum -- a small-cell cancer of the lung, rather, grow into the mediastinum?
A. Yes.
Q. And is that a fairly typical presentation of a small-cell lung cancer; that is, that it extends into the mediastinum?
A. It's certainly not uncommon.
Q. Do you have any idea how many times you've seen that radiographically when the diagnosis was small-cell lung cancer?
MR. BARRON: For clarification, because it's ambiguous, by "that" you mean some what appears to be extension from the lung into the mediastinum?
MS. CHABER: Q. Correct.

A. No, I have no idea.

Q. Do you know if you've seen it more frequently than you've seen a thymic cancer?

A. Well, I don't know that I've seen it, because oftentimes, as I think I mentioned earlier, I don't get feedback on what the pathology is.

Q. You're aware in this case that the pathology is small-cell?

A. Yes.

Q. And with respect to the commonality of the small-cell lung cancer extending into the mediastinum or primary thymic cancer of the small-cell variety, do you know which is more common?

A. Small-cell carcinoma of the lung is more common.

Q. Do you know by what ratio?

A. I don't know what ratio, but it's -- you know, without giving numbers, because I don't know what the numbers are, it's much more common. And "much" to me, you know, it's a subjective word, and we don't want to play with subjective words here, but it's more common.

Q. Do you have any opinion as to what is the cause of Ms. Henley's neoplasm?

A. No.

Q. Do you have any opinion as to what agents are associated with Ms. Henley's neoplasm?

MR. BARRON: Objection. Lack of foundation, and ambiguous.

THE WITNESS: Well, I'm not really sure what you mean by "agents." But I really don't know that much about Ms. Henley, and really, I just know about the films. And I don't know what caused the finding that we know represents a neoplasm.

MS. CHABER: Q. Let's go to the films.

Doctor, could you put up the January 3rd PA and lateral?

(Discussion off the record.)

(Films were placed on the light box.)

MS. CHABER: Q. Would you please read the PA film?

A. I'm sorry, the PA film?

Q. Yes.

A. Sure. There's soft tissue fullness in the left suprahilar region, with obscuration of the aorta which may be due to the copying technique of this film.

Heart size within normal limits. There's no pleural effusion. The trachea is midline.

It's probably -- when we talk about the aorta, there's suggestion of some increased soft tissue superior to the aortic arch, although I just don't know if it's a function of a second- or third-generation copy of this film.

Q. Do you see any evidence of any -- I take it what you have described is an abnormality?

MR. BARRON: Well, I have to object, because of the, quote, "that" that you've described, close quote.

He mentioned, for example, I think heart within normal limits. You don't mean to imply that's an abnormality? So I think you need to break it down as to

what the "that" is.
THE WITNESS: Read me his answer back, please.
(Record read.)
MS. CHABER: Q. When you describe soft tissue fullness in the left hilar region, is that a description of an abnormal or normal finding?
A. Actually, I said left suprahilar region, and to me it's pathologic.
Q. What do you mean by pathologic?
A. It's not normal.
Q. And do you see any other abnormalities or things that are not normal in that PA film?
A. No.
Q. Do you see an infiltrate in the superior segment of the left lower lobe?

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A. No.
Q. Now, on the lateral view, are there any abnormal findings that you see?
A. Yes.
Q. What?
A. There's increased soft tissue opacity in the superior retrosternal space, and there's increased density superimposed over the aortic arch and suprahilar region.
Q. Can you determine whether the density that is seen on the lateral view is a density within the lung?
A. No.
Q. Do you believe it is a density located elsewhere than the lung?
A. Well, I can't make that determination on the basis of this exam alone.
Q. Let's go on to the CT scan.
A. There's a lot of images here. What would you like?
Q. Why don't you tell me which images you believe demonstrate a mediastinal lesion in the left hilar region that's representing a soft tissue opacity.
And as I think we've discovered before from these films, the windows are very -- or the images are very confusing. So if you can clarify which image --

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A. Sure.
Q. -- by number or whatever other identifying thing you can, that would be appreciated.
A. Sure. These are images that are obtained following administration of intravenous contrast. And just for purposes of clarification, they are labeled plus C. And we will assume, until stated otherwise, that these are all referring to the contrast-enhanced images, and they are numbered. And there is clearly mass imaged on number 7, 8, 9, 10, 11, 12 and probably 13 and 6.
Q. And when you say -- can you just show me in one of the images what you're referring to?
A. Sure. X-rays show us differences in densities, and that's one of the ways that we can find things.
In this particular exam, Ms. Henley received iodinated contrast, which makes her blood vessels look white on these images. And if we look, for instance, at image number 9, there's a white almost comma-shaped

structure that represents the aortic arch. And as we're looking at the film, to our right, there's this soft tissue opacity that extends basically the entire length of the aortic arch that is darker, it's gray. And that is that lesion, that soft tissue opacity.

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Q. And what generally in the absence of a mass rests against the aortic arch?

A. Lung.

Q. And is that mass that is seen there within the lung?

A. I don't think so.

Q. And why don't you think so?

A. Well, when we pull out the lung windows, and we image data that's acquired on a CAT scan, either -- well, any one of a number of ways. But for CT scan, we look at them with soft tissue windows, and we look at them with lung windows.

And when we look at the lung windows, we see nothing that looks to me like this mass is in the lung.

I do see some patchy hazy opacity that we've talked about before that relates in close proximity to this lesion, but my experience as a radiologist is that this is extraparenchymal.

Q. And what happens when you look in the mediastinal windows? Are you able to still see lung tissue in the mediastinal windows?

A. Actually -- well, again, there's soft tissue windows and lung windows. And I don't know if you mean by mediastinal windows the soft tissue windows.

Q. I guess I do.

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A. All right. I've heard it described as mediastinal -- it's probably reasonable. So it's -- soft tissue windows are more descriptive, because I'm really looking at soft tissue.

On the lung windows, you still see mediastinum; you just don't see it particularly well.

I'm sorry, what was the question on the mediastinal or soft tissue windows?

Q. Yes. Are you able to see any structures or abnormalities within the lung?

A. Well, you don't see the lung particularly well on these images. That's one of the problems.

But nevertheless, I don't see anything outside that area that's clearly in the lung. I see what to me looks like a mediastinal and left hilar lesion.

Q. In these images that we're looking at of the soft tissue, the lung is represented by the black?

A. That's correct.

Q. And what does the white represent?

A. Which white?

Q. Well, there's different whites. Correct?

A. That's why I'm asking you which white.

Q. You had described earlier that white in the lung windows represented, I believe you said, blood vessels?

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MR. BARRON: Hold on. I don't think intentionally, but unintentionally, you have mixed several responses together of his.

MS. CHABER: I can guarantee you it's not intentional, because I couldn't possibly be doing --

MR. BARRON: Why don't you try to restructure it in a different way, then, the question.
MS. CHABER: Q. Why don't you describe for me the different aspects of the window and how the structures are separated by color and gradation of color.
A. Actually, we don't use color, because this is a black and white and shades of gray --
Q. Well, I think black and white are a color. It's just my art background.
A. Let's go back to image number 9, which we've talked about before.
We have this very white comma-shaped structure that's right in the middle of the chest. That represents the aorta. And the reason that it's white is because Ms. Henley received iodinated contrast, which is very dense to x-ray. So it appears opaque to the receptors that pick up the x-ray beam, and the computer generates it as a white object. It is reflecting contrast.

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Bone is also radiopaque, and when it is reconstructed by the computer, it also looks white. Lung is not particularly radiopaque. The x-ray goes through it without leaving much information on these images, so it looks relatively darker. In fact, it's black on these images.
And then we have various soft tissue structures which have an intermediate radiopacity, whether they are muscle or this soft tissue opacity in the mediastinum.
Q. Is there a gradation of grayness, for want of a better explanation, of the color, along the soft tissue density that you are describing?
A. Well, it's slightly heterogeneous. You know, I'm not really sure what to make of that.
Q. And do you see in any of these soft tissue windows in the lung area any white areas that represent abnormality?
For example -- I don't know what number this is, I think you said it was 9, these little areas of white in the left --
A. Those are probably pulmonary vessels. The left pulmonary artery is being compressed.
Q. And can you tell us in any of the films whether you saw a narrowing of the left main stem

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bronchus?
A. It's possible, although I'm not a hundred percent certain.
Q. And did you see any emphysematous changes in the upper lobes?
A. No. Actually, I think you already asked me if I saw any emphysematous changes. In fact, I know that you already asked me. And I believe I said I saw some quite mild changes.
Q. I'd like you to identify which windows it is that you see those in.
A. Well, if we look on image number 6, for instance, there is -- maybe it's better to pick image number 9. Since we've been going with that one, why don't we stay with it.
There is a relative opacity, to a mild degree,

on these lung windows of linear markings which represent blood vessels and interstitium that are extending out the latticework that supports the lung, which to me suggests some mild bullous change.
Q. Did you review the 5 millimeter cuts as well as the 10 millimeter cuts?
A. Yes, I did.
Q. Do you see any abnormalities that you can identify in those 5 millimeter cuts?

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A. Well, I see the soft tissue opacity that we've been talking about.
Q. And in any of the films that you reviewed, whether precontrast, contrast, high-resolution or normal, did you see any evidence of a residual thymic gland?
A. No.
Q. Where would the thymic -- first of all, which cut would be a cut that you could determine, or which cuts -- when I say cuts, images, windows -- where you could determine whether there was a residual thymic gland present or not?
A. Well, those cuts that include the superior part of the mediastinum.
Q. And can you tell me which ones those would be?
A. You know, on these thin -- the 3 millimeter slice images, I would say anywhere from -- possibly from image 5 up to image 1, which is as high as it goes, which is only to the superior aspect of the aortic arch, or possibly the post contrast images.
And they don't align perfectly, but it looks like going up from the image number 1 on the noncontrast study, which approximates image 8 plus C. We're probably not going to see a whole lot in the way of 7 plus C. So in that general vicinity.

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Q. Could you put up the precontrast film?
A. Sure.
Q. Could you look at image number 4 on the precontrast?
A. Yes.
Q. Do you see any evidence of a residual thymic gland?
A. No.
Q. Do you see any evidence of a fat density?
A. There is some fat density there.
Q. And what is that?
A. It's fat.
Q. In any of the CT scans from the January 3rd date, did you see any increase in interstitial markings in the left mid to upper lung field?
A. I see increased opacity in the superior aspect of the left lower lobe, which may be prominence of the interstitium. It's what we've referred to earlier in this deposition as some hazy opacity in the left lower lobe, which I think may represent some atelectasis.
Q. Could you put up the 2-5-98 films? There's a PA and a lateral.
MR. BARRON: We've been going for quite a bit. Do you want to take about 5 minutes?
MS. CHABER: Yeah. This one will be quick, so

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can we just do one, and then we'll stop? Because what

you do to me all the time is, then you make me lose my train of thought, and it takes longer.

MR. BARRON: Are you suggesting I can do that?

MS. CHABER: Make me lose my train of thought?

MR. BARRON: Yes.

MS. CHABER: Almost any human being can do that. And you're very good at it.

MR. BARRON: Really?

MS. CHABER: Yes.

THE WITNESS: Is there just one view on this film?

MS. CHABER: Q. There's a PA, and there's a lateral also.

A. It's possible we don't have it in this jacket, so -- you'll just need to bear with me for a moment.

MS. CHABER: I don't want you to spend the time, and we'll do that at a break looking for the lateral on this.

But do you see -- can you describe any abnormalities that you see in this film?

A. Yes. There is parenchymal opacity in the left hemithorax which has an interstitial to alveolar appearance, which is predominantly left perihilar and infrahilar. And we're losing a lot of detail, because

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this is a copied film, so the left base is obscured.

Q. Can I stop you there for one second?

What do you attribute that parenchymal abnormality to?

A. Atelectasis, pneumonia.

Q. Neoplastic spread?

A. I would doubt that.

Q. Go ahead. I stopped you.

A. As I was saying, that there's -- we're losing detail of the left base because either the film was compromised by technical factors when it was acquired, or technical factors in the photographic reproduction, or there's a legitimate process going in the left base, which could be pleural or parenchymal.

Q. Do you see any evidence of a pleural effusion?

A. Well, that's what I'm saying. I don't know. You can't tell.

MS. CHABER: All right. Let's take a break.

(Recess from 11:32 a.m. to 11:48 a.m.)

MS. CHABER: Q. Dr. Rosenbach, on the -- I've put up the 1-3-98 on the right-hand side of the light box. Those are the lung windows. Correct?

A. Correct.

Q. And can you tell me what the image number is --

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A. Sure. If you look in the upper left-hand corner, 3, 4.

Q. Okay. And this is plus C?

A. It meanings the contrast has been administered.

Q. And you're able to visualize a portion of the lung tissue?

A. On which image?

Q. On 3-C?

A. Sure. Yes.

Q. And the darker, almost black, is what in that picture is represented as lung tissue?

A. Well, actually, no. It's air.
Q. Air.
A. That's air. I mean, air is black, you know. Lung tissue, you know, unless it's so microscopic, you know, alveoli, obviously we can't see an alveolus on a CT scan. So yes, in a way the black is alveolus. But for the most part, it's air.
Q. And the patient's left lung is the part appearing on our right?
A. That's correct.
Q. That always drives me crazy.
A. That's the standard protocol.
Q. Okay. In the left-hand side of the -- what is

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the patient's left lung, can you tell me what this white irregular image is?
A. Well, that's interesting. How do you like that?
No, I can't exactly tell you what it is. It just so happens that when they filmed this CT scan on the soft tissue or mediastinal windows, they neglected to give us image 3. They repeated image 2 twice.
So in the absence of that image, I'm not sure what that is. I'd like to have that. It could be volume averaging from the lung, or from the lung apex. I'm not sure what it is.
Q. Could that be a density in the lung?
A. It could be, but I'm not all that crazy about it.
Q. Would it be unreasonable for a physician to conclude that that represented a density in the lung?
MR. BARRON: Objection. Ambiguous as to the phrase, quote, "unreasonable," close quote, and argumentative as phrased.
THE WITNESS: I don't know if it would be unreasonable. For me, I wouldn't call it a density in the lung.
MS. CHABER: Q. Would it be below the standard of practice in the community in which you

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practice for a doctor to call that a density in the lung?
A. I don't think that it would be below the standard, but I don't think -- there are a lot of things that you can do or not do that fall within the standard. And it's always better to overcall than it is to undercall, which is just the way the medical-legal climate is, unfortunately. But I wouldn't call that a mass.
Q. But other doctors within your community might and not be considered to be practicing below the standard of care in that community. Correct?
A. Probably --
MR. BARRON: I'm going to object also on the basis that it's -- besides being argumentative, it's an improper hypothetical without enough predicates to allow a meaningful answer.
THE WITNESS: I don't know what other physicians might do. If they might call it, no one's going to say, holy smokes, there's a violation of the standard.
MS. CHABER: Q. And Ms. Henley's treating physicians all have diagnosed her with having a

small-cell lung cancer, have they not?
A. I don't know what all the treating physicians did.
Q. Did you see any of the reports of her treating physicians?
A. Yes, I did.
Q. Did you see any reports of her treating physicians that diagnosed her as having a small-cell lung cancer?
A. Yes, I did.
Q. Did you see any reports of her treating physicians diagnosing her as having a small-cell lung cancer of the thymus?
A. I don't know that you can have a small-cell lung cancer of the thymus.
In my review of the records, I didn't see any reference to a small-cell cancer of the thymus.
Q. Did you see any reference to a small-cell cancer of any other part of the body?
A. No, I didn't.
You know, just as a caveat, once somebody's labeled with a diagnosis, it just propogates all by itself, kind of like a snowball rolling downhill. If somebody tells me somebody has a small-cell carcinoma the lung, I'm not going to do a lot to disprove it as a radiologist, and it might be incorporated in the report either because that's how it's been submitted as an historical factor, small-cell carcinoma, or more likely lung cancer.
But I don't know if I answered your question.
Q. I don't think you have, but I'm not sure what the question was any more.
Did you see the report of the doctors that performed the surgery on Ms. Henley concluding that she had a lung cancer?
MR. BARRON: Objection. Misstating the evidence. Argumentative as phrased.
THE WITNESS: I'm not sure which report you're referring to.
MS. CHABER: Q. Did you see any reports from Dr. Hagen, who was one of the surgeons who performed surgery on Ms. Henley to determine the cause of her illness, concluding that this was a 51-year-old woman with lung cancer?
A. Can you make that report available? I just don't know what you're talking about. I'm not trying to be cagey or obstructionist; I'm just not sure which report you're referring to.
Q. I'm just asking you at this point if you remember. I'd be happy to show you reports after.
Do you remember the surgeons who performed the surgery on Ms. Henley concluding that she had lung cancer?
MR. BARRON: Objection. Argumentative as phrased, and misstating the evidence.
THE WITNESS: No, I don't recall that.
MS. CHABER: Q. And you do know that the oncologist who is treating her has concluded that she has lung cancer?
A. I'm not -- when you say do I know, I know

somebody concluded. I don't know who it is. And if you're telling me the oncologist, I'll take your word for it.

Q. Did you see records of the oncologist in Mrs. Henley's care?

A. I did. But as we stated very early on today, I didn't memorize them, and I do not have an encyclopedic knowledge of them.

Q. The left -- my left, your left-hand sheet that we've put up, what windows are those?

A. Well, it's a combination. On the upper half of the film is lung windows, and the lower half of the film is soft tissue windows.

Q. And on the lower half of the film, are those 5 millimeter cuts?

A. Well, actually, they're a -- yes, they're 5-millimeter cuts. Intervals, actually.

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Q. And the third window from the top on the left-hand side, which would be image number 4 of the 5-millimeter cuts --

A. Yes.

Q. Can you tell me on the central area, upper part, what this apparently triangular object is?

A. It's some fat.

Q. Does all of this light grayish area, as compared to the black area of the lung, represent fat?

A. Well, I don't know if all of it represents fat, but it's predominantly fat. There is some linear stranding there.

Q. And what is that?

A. Some linear stranding. Some planes between fat.

Q. And is that fat connected to any anatomical body part?

A. Well, it's in the mediastinum.

Q. You can -- I'm not going to ask you about these.

Do you agree or disagree with the following statement: Small cell carcinoma of the lung is known to metastasize massively to the mediastinum at a very early stage when the primary is not detectable by radiographic means?

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A. It's known to, yes.

Q. Do you know what mechanism would cause hemoptysis in an individual with a soft tissue neoplasm?

A. No.

Q. Are you aware of any mechanism that might do that?

A. It's really outside my realm. I don't feel comfortable to really address it.

Q. Do small-cell lung cancers typically present are hemoptysis?

A. I don't know.

Q. Is there a typical presentation clinically of a soft tissue neoplasm such as you've diagnosed in this case?

A. I don't know. Really, I'm not a clinician, insofar as examining people and understanding how they present.

I think I am a clinician insofar as interpreting radiographs, which is clearly clinical

medicine.
Q. When you are sent radiographs to review in your clinical practice, are you generally given some clinical information?
A. Usually, although I'm often frustrated by how irrelevant it is.

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Q. And do you have anything in particular in mind when you talk about how irrelevant it is?
A. Sure. Let's take an example. An x-ray of the hand, for instance.
I have three views, and the history will be pain. Well, that doesn't really help me very much. I mean, I know something's going on; otherwise, I wouldn't be doing it. We don't typically take x-rays unless there's a reason.
So pain, which is the most common -- well, I don't know about that, but it's one of the most common reasons that we do an extremity film, doesn't help me.
Q. Are there some clinical facts that help you in making a radiologic interpretation of the chest?
A. Previous surgery, trauma, no neoplasm, or some underlying, known pathology.
For instance, somebody might specifically be looking for a pneumonia in a child with asthma, for instance.
Q. And then it would be significant for you to know that that person had asthma?
A. Well, yes, because there are findings on a chest radiograph that are associated with asthma that we can say, hey, this probably makes sense; this is an asthmatic child. The findings probably represent

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asthma.
Q. And are you ever given a history of cigarette smoking when you are reviewing films for potential abnormalities or disorders of the chest?
A. Well, again, "ever" is a very big word, or at least its implications are big.
I don't want to say never. But I would say, typically, no.
Q. If an individual has a suspected exposure to a carcinogenic agent, are you typically provided that information to help you rule in or rule out certain diseases of the chest?
A. No.
Q. Have you ever diagnosed mesothelioma?
A. Well, I don't know that I've diagnosed it, but it's -- at least when I was a resident, I think it was suggested on a case.
Q. Have you ever rendered an x-ray or CT scan report wherein you noted pleural plaquing?
A. Yes.
Q. And have you ever noted pleural plaquing and noted that it was typical of plaque caused by asbestos?
A. When it's calcified, I would suggest that. I would say that there's calcified pleural plaque that suggests asbestosis -- I'm not -- not asbestosis, but

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asbestos exposure.
Q. And do you consider calcified pleural plaques pathognomonic of asbestos exposure?
A. No.

Q. Do you make any determination in your review of radiographs whether it's a neoplastic disease that -- do you make any distinction between a limited and extensive disease?
A. Could you define those, please?
Q. I'm just asking if that's terminology that you use in describing neoplastic diseases of the chest.
A. You mean, do I have a report that says, there is limited neoplasm, or there is extensive neoplasm?
Q. I just asked if those -- are those words that you use?
A. Right. And that's what I'm asking you. That's exactly what I'm asking you.
Q. Yes.
A. No, I do not use those words.
Q. In reviewing the x-rays and CT films, did you see any residual neoplasm?
A. I don't know. There is some soft tissue opacity on the October CT scan that may well represent scar or scarred-down lung or scarred-down mass.
Q. Could you find what windows you're referring

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to?
MR. BARRON: Off the record.
(Discussion off the record.)
MS. CHABER: Q. You indicated that there was something residual on the film. I asked you to identify what --
A. Actually, I didn't know if it was residual. I didn't identify it as residual. There's an opacity there. I don't know if it's residual. It could be. It could be something that's new, a scar.
Q. And could you tell me what images you see it in?
A. Image 8, 9, 10. That's the images.
Q. And can you indicate and hopefully describe what you're indicating?
A. There is some opacity that relates to the aortic arch in the region where we saw the mediastinal lesion on the January exam, and there's some pleural thickening and some linear stranding in that vicinity.
Q. And you have no opinion as to what it is --
A. Well, it could be various things. It could be scar, it could be residual tumor, it could be post-radiation change, if we want to separate that from scar.
Q. Do you have an opinion as to what is your

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reasonable degree of medical probability that it is?
A. No.
Q. Those are the differentials that you would indicate?
A. There's probably other things, but that's pretty much what I would come down with.
Q. And what you've described as seeing in those three images, is that in the lung?
A. Some of it's in the lung, some of it's in the mediastinum, and some of it I can't tell if it's arising from the pleura.
Q. What does it mean when a doctor describes a neoplastic mass extending into another organ?
A. I don't know what that means.
Q. Let me see if I can find the specific

language.
Doctor, do you smoke cigarettes?
A. No.
Q. Have you ever?
A. Oh, one or two or three or four in my entire life.
Q. And when was that?
A. I was an intern in family practice.
Q. What year was that?
MR. BARRON: Please hold your answer for a
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minute.
This is similar to the area that came up yesterday with Dr. Missett. I think you and I discussed this on the record, and it was my understanding that you said at the time something along the lines of, it was appropriate, because it had to do with issues of addiction and the balance of discovery relevance, and whatever privacy rights there are did not really apply when you were dealing with that type of a person. And I talked about your objection with Dr. Horn to a certain inquiry in that regard.
I think I'd like to have some guidance from you as to whether you're going to allow all your witnesses, even though they're not talking about issues of addiction or dependence, to be asked the same questions without limitation; or whether you see that for some reason the standard should be different with our witnesses than yours, and if so, why.
MS. CHABER: Counsel, there were specific limitations stated at Dr. Horn's deposition. I did not object until you started asking questions about his wife and any efforts she may have made or he may have made towards getting her to quit, which I thought went beyond and went into privacy issues, not to mention marital privilege issues.
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However, I have not stopped you, and you have asked those questions, at every single deposition, with I think the exception of Dr. Hammar, and -- that either was oversight or you already knew the answer to that question.
I don't think that the question to this witness as to what year that was that he smoked cigarettes is a particular invasion of privacy.
MR. BARRON: Well, let's just see if we can't define this, then, for our mutual benefit.
First of all, when you say I asked the question, I think you meant that generically, since I haven't taken a deposition yet of your witnesses.
MS. CHABER: It was Mr. Ohlemeyer, obviously.
MR. BARRON: Then are you suggesting that where one draws the line is where one asks about a spouse and that spouse's habits and what conversations occurred?
MS. CHABER: Counsel, what I will say is where one draws the line is where one objects and draws those lines. And in a vacuum, I will not say, this is the line that will be drawn and this one will not.
I have made a particular objection at a particular time based on a particular question that occurred after numerous other questions along the same
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line that did not get objected to and that were allowed to be asked. And if you have a specific objection to the particular question that I have asked this witness, make your objection, and we'll go from there.

I don't want to get into long, philosophical discussions with you of what may or may not be areas of inquiry, appropriateness on questions that I haven't heard asked or have not asked myself.

MR. BARRON: Well, I don't want to engage in a long, quote, "philosophical discussion," close quote, either.

I was engaging in a discussion so that each of us would, as a meet-and-confer process, be able to understand what we can agree on as to the limits, if any, into inquiring into smoking behaviors of witnesses or people with whom they live or have been friends with or whatever it might be.

If we couldn't get some kind of an understanding, then I will have to do what you suggest. I was just hoping we could explore it, in light of the objection you made with Dr. Horn, so that I can intelligently go about not impeding the deposition but making objections only if I needed to to make sure that my witnesses were treated in the same way that your witnesses you want to be treated.

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So I think we understand each other, so let's go ahead.

MS. CHABER: Fine. Are you objecting to that question?

MR. BARRON: Not in light of what you gave as an explanation for your comments or objections at Dr. Horn's deposition.

MS. CHABER: Q. After all of that, do you have the question in mind?

A. What is the question?

Q. What year was that when you smoked your one, two, three, four or five cigarettes?

A. I'm not sure. 1981 or '82 or '83.

Q. And I take it it was a practice that you did not continue?

A. Well, actually, it was at a party, you know. And actually, friends got together to play the board game Risk. I don't know if you've ever played that.

Q. Oh, yes.

A. And those were long affairs, and you'd have wine and a cigarette -- it just so happened that the people who hosted the party smoked -- and just partake. And yes, I did not continue after that.

Q. Do you believe that there are any diseases or disorders identifiable by radiograph that are associated

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with cigarette smoking?

A. Yes.

Q. What?

A. Lung cancer, COPD.

Q. Anything else?

A. Not coming to mind right now.

Q. Other types of cancer, like laryngeal cancer? Or were you limiting your answers to the chest, I guess is --

A. You asked me about chest, so I limited it to chest.

Q. I didn't remember limiting it, but fine.
Within COPD, what diseases or disorders do you include within that rubric?
A. I use COPD as a -- kind of a wastebasket diagnosis, and I don't really break it down into -- I don't know what you have in mind.
Q. Emphysema?
A. Well, I already explained earlier during this deposition that I don't use the term "emphysema" in any of my reports.
Q. You use the term "bullous changes"?
A. I use "bullous change," and I use "COPD."
Q. Do you use the term "hyperinflation"?
A. Well, I use that term, but that doesn't

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necessarily mean anything.
Q. Are there any disease entities within the rubric of the term -- or the wastebasket, I think you said, of the term COPD that you associated with cigarette smoking?
A. I'm just not sure what specific diseases you have in mind, and I don't typically break it down.
Q. If you see changes that you believe may be associated with cigarette smoking, do you generally describe them as COPD?
MR. BARRON: Can I have that reread?
(Record read.)
MR. BARRON: I think the question is ambiguous and/or unintelligible in light of his previous answer about associating lung cancer. And I'm not sure whether you're trying to just deal with the issue of COPD --
MS. CHABER: I was.
MR. BARRON: Well, then if you listen to the question, I think you'll see it's -- it should be rephrased. Listen to it back.
MS. CHABER: I don't -- I don't want to -- I'd like to get this depo over as much as you would.
Q. Did you see evidence of metastasis to any other part of Ms. Henley's body, other than the chest area?

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A. Well, I'm not sure that I'm prepared to say that she has metastasis at all. You're saying other than the chest; I don't know that that's metastatic disease.
And outside the chest, I see no evidence of metastatic disease, anywhere.
Q. Did you review the MRI of the brain?
A. Yes, I did.
Q. Did you see in the medical records that there was a reference to possible metastasis to the clivus?
A. Clivus?
Q. Clivus?
A. I did see that.
Q. And did you see anything that was evidence of possible metastasis to the clivus?
A. No.
Q. Clivus -- still can't --
A. Clivus. Long "i."
Q. And you reviewed bone scans?
A. Yes.
Q. Did you see any evidence of metastasis to any bone?

A. No.
Q. Do you have any opinion as to Ms. Henley's life expectancy or prognosis?

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A. No.
Q. Do you have any opinions regarding the appropriateness or inappropriateness of Ms. Henley's treatment and care?
A. No.
Q. Do you ever do, in your clinical practice, any conferencing or correlation between what you're seeing on radiograph of the chest and pulmonary function studies?
A. No.
Q. Do you have any expertise in the evaluation of pulmonary function studies?
A. No.
Q. Do you have any knowledge or expertise on the correlation of COPD to pulmonary function studies?
A. No.
Q. Do you have any knowledge or expertise on the correlation of bullous changes to pulmonary function studies?
A. No.
Q. Let me just look through my notes, Doctor, and I think we're just about out of here.
How much time have you put into this case so far, up to the time of the deposition?
A. Maybe 5 hours.

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Q. And is that 5 hours at 300 an hour?
A. 350.
Q. 350. And have you billed the Shook, Hardy law firm for that?
A. I don't know. I don't take care of the billing.
Q. And while you're here and hopefully still on salary, are your expenses being paid for by the attorneys?
A. By Shook, Hardy, yes.
MR. BARRON: Speaking of expenses, just to let you know, we're at approximately 12:30, which is an extra hour and a half. And so if you are close to finishing, I just wanted to --
MS. CHABER: I said I was almost done.
MR. BARRON: Don't take offense. I was trying to let you know that it would be just an hour and a half in terms of extra billing if you were going to wrap it up soon.
MS. CHABER: Q. Yes. And here's another check for $600, Doctor. And I ask you or whoever does your billing to bill me for the remainder. I believe I gave you a card.
A. Yes, thank you.
Q. Is there a way to distinguish radiologically

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between atelectasis, scarring or neoplasm?
A. Something sophisticated like a PET scan might be able to differentiate those possibilities. As far as routine radiography or CT scan, it's not clear to me.
Q. And I think you just used the words radiation change. Is that correct, that --
A. I used it a while ago, yes.

Q. What did you mean by that?
A. Well, radiation has an effect on the lung and other structures that it interacts with. And when a lung is irradiated, there are going to be consequences that can be demonstrated radiographically.
Q. Is there a way to radiographically distinguish between radiation changes and scarring and neoplastic response when we're talking about the lung?
A. Actually, I -- when you asked me before, I thought you specifically meant a lung, because the only place you can get atelectasis is the lung. And my answer is the same as it was to your previous question, which as far as I can tell was pretty identical.
Q. Is radiation change the same as atelectasis? I didn't think my last question had the word "atelectasis" in it at all.
A. It's irrelevant.
Q. But I don't want to argue with you over that.

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Is there a way to distinguish between radiation change in the lung and neoplastic process?
A. Radiographically?
Q. Radiographically.
A. Not that I'm aware of.
You know, I'm sorry, I just want to amend that for one second. Surveillance, time; take an x-ray now and take an x-ray in 3 months, 6 months, and see what's happened to the area of interest.
Q. And what do you mean -- what would you expect, based on the --
A. Well, if it's a neoplasm, you would expect that it would grow. And if it's scar, it will either not change or it might retract.
MS. CHABER: I think I'm done. I don't think I have anything else.
MR. BARRON: And I have no questions at this time.
(Exhibits 1, 2 and 3 were marked.)
(Time noted, 12:34 p.m.)
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Signature of the Witness

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